A. COORDINATION OF BENEFITS

The Wisconsin Medical Assistance Program (WMAP) is the payer of last resort for any WMAP-covered service. If the recipient is covered under health insurance (including Medicare), the WMAP reimburses that portion of the allowable cost remaining after all health insurance sources have been exhausted. Refer to Section IX of Part A of the WMAP Provider Handbook for more detailed information on services requiring health insurance billing, exceptions, and the "Other Coverage Discrepancy Report."

Psychotherapy and AODA services provided to a recipient which have been paid for by another health insurance payer count toward the yearly 15 hour/$500 threshold beyond which prior authorization is required.

B. MEDICARE/ MEDICAL ASSISTANCE DUAL ENTITLEMENT

Recipients covered under both Medicare and Medical Assistance are referred to as dual-entitlees. Claims for Medicare-covered services provided to dual-entitlees must be billed to Medicare prior to billing Medical Assistance.

If the recipient has Medicare, but Medicare benefits are not available (e.g., Medicare benefits exhausted), a Medicare disclaimer code must be indicated on the claim, as indicated in the claim form instructions in Appendix 1 of this handbook.

C. MEDICARE QMB-ONLY

Qualified Medicare Beneficiary only (QMB-only) recipients are only eligible for WMAP payment of the coinsurance and the deductibles for Medicare-covered services. Since Medicare does cover some psychotherapy/AODA services, claims submitted for QMB-only recipients for Medicare-allowed services may be reimbursed.

D. BILLED AMOUNTS

Providers must bill the WMAP their usual and customary charge for services provided, that charge being the amount charged by the provider for the same service when provided to private-pay patients. For providers using a sliding fee scale for specific services, usual and customary means the median of the individual provider's charge for the service when provided to non-Medical Assistance patients. Providers may not discriminate against Medical Assistance recipients by charging a higher fee for the service than is charged to a private-pay patient.

The billed amount should not be reduced by the amount of recipient copayment. The applicable copayment amount is automatically deducted from the payment allowed by the WMAP.

Providers should refer to Appendix 1 of this handbook for complete billing instructions.

E. CLAIM SUBMISSION

Paperless Claim Submission

As an alternative to submission of paper claims, EDS is able to process claims submitted on magnetic tape (tape-to-tape) or through telephone transmission via modem. Claims submitted electronically have the same legal requirements as claims submitted on paper and are subjected to the same processing requirements as paper claims. Providers submitting electronically may usually reduce their claim submission errors. For additional information on paperless claim submission, complete the form found in Appendix 21 of this handbook or contact the Electronic Media Claims (EMC) Department at:

EDS
Attn: EMC Department
6406 Bridge Road
Madison, WI 53784-0009
(608) 221-4746

E. CLAIM SUBMISSION (continued)

Paper Claim Submission

Claims for psychotherapy and AODA services must be submitted using the National HCFA 1500 claim form. Sample claim forms and completion instructions may be found in Appendices 1 and 2 of this handbook.

Claims for psychotherapy and AODA services submitted on any other paper form than the HCFA 1500 claim form are denied.

The HCFA 1500 claim form is not provided by the WMAP or EDS. It may be obtained from a number of forms suppliers.

One such source is:

State Medical Society Services
Post Office Box 1109
Madison, WI 53701
(608) 257-6781 (Madison Area)
1-800-362-9080 (Toll-Free)

Completed claims submitted for payment must be mailed to the following address:

EDS
6406 Bridge Road
Madison, WI 53784-0002

Submission of Claims

All claims for services rendered to eligible WMAP recipients must be received by EDS within 365 days from the date such service was rendered. This policy pertains to all initial claim submissions, resubmissions, and adjustments.

Exceptions to the claim submission deadline and requirements for submission to Late Billing Appeals may be found in Section IX of Part A of the WMAP Provider Handbook.

F. TYPES OF PROVIDERS

Billing Providers

Psychotherapy clinics, psychiatrists, psychologists, AODA clinics and physicians are issued billing performing provider numbers which may be used to independently bill the WMAP. All claims must indicate the billing performing provider name and number on the HCFA 1500 claim form. Services performed by billing performing providers may be billed by:

- Indicating the billing performing provider name and number in element 33 of the HCFA 1500 claim form (in which case all payment is made directly to the billing performing provider.)

Non-Billing Providers (Master's Degree Psychotherapists or AODA Counselors)

Master's degree psychotherapists and AODA counselors are issued non-billing performing provider numbers which may not be used to independently bill the WMAP. All claims must be billed under the group or clinic provider name and number. Services performed by the non-billing performing provider may be billed by:

- Indicating the non-billing performing provider number in element 24K of the HCFA 1500 claim form AND the group or clinic provider name and number in element 33 of the HCFA 1500 claim form (in which case all payment is made directly to the group or clinic provider number.)

G. DIAGNOSIS CODES

All diagnoses listed on the HCFA 1500 claim form must be from the International Classification of Diseases, 9th Edition, Clinical Modifications (ICD-9-CM) coding structure. An allowable diagnosis code must be indicated for each procedure performed. Refer to Appendix 3 of this handbook for allowable diagnoses for specific procedure codes.

Claims received without the appropriate ICD-9-CM code are denied.

The complete ICD-9-CM code book may be ordered by writing to the address listed in Appendix 3 of Part A of the WMAP Provider Handbook.

Providers should note the following diagnosis code restrictions:

- Codes with an "E" prefix must not be used as the primary or sole diagnosis on a claim submitted to the WMAP.
- Codes with an "M" prefix are not acceptable on a claim submitted to the WMAP.

Providers should note that the Prior Authorization Request Form (PA/RF) also requires ICD-9 diagnosis codes, but the prior authorization attachment forms request the most recent version of DSM diagnosis codes.

H. PROCEDURE CODES

HCFA Common Procedure Coding System (HCPCS) codes are required on all psychotherapy and AODA claims. Claims or adjustments received without HCPCS codes are denied. Allowable HCPCS codes for psychotherapy and AODA services are included in Appendix 3 of this handbook.

Some HCPCS procedure codes are from the American Medical Association's Current Procedural Terminology (CPT) code book. The complete CPT code book may be ordered by writing to the address listed in Appendix 3 of Part A of the WMAP Provider Handbook.

I. CHEMOTHERAPY MANAGEMENT (MEDICATION CHECK)

Chemotherapy management performed by an RN must be billed by a private physician clinic or a certified mental health clinic. When performed by an RN, enter the RN's eight-digit Medical Assistance provider number in element 24K of the national HCFA 1500 claim form. If the RN does not have a Medical Assistance provider number, enter the provider number of the supervising physician.

Up to 30 minutes of chemotherapy management may be billed per date of service and up to one hour per calendar month.

J. FOLLOW-UP TO CLAIM SUBMISSION

It is the responsibility of the provider to initiate follow-up procedures on claims submitted to EDS. Processed claims appear on the Remittance and Status Report either as paid, pending, or denied. Providers are advised that EDS takes no further action on a denied claim until the information is corrected and the claim is resubmitted for processing. If a claim was paid incorrectly, the provider is responsible for submitting an adjustment request form to EDS. Section X of Part A of the WMAP Provider Handbook includes detailed information regarding:

- the Remittance and Status Report;
- adjustments to paid claims;
- return of overpayments;
- duplicate payments;
- denied claims; and
- Good Faith claims filing procedures.